MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a)

11496

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:
County Carroll
City or town Ridgeville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 7 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Somerset
City or town Saint Inigoes Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rev. John Matthews Barnes
3. (b) Social Security Number

4. Sex male
5. Color or race Colored
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Hattie Barnes
6(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Sept. 18 1882
8. AGE: Years 58 Months 1 Days 30 If less than one day hrs. min.
9. Birthplace Somerset Co. Md. (Town, county, and state)
10. Usual occupation Preacher
11. Industry or business
FATHER 12. Name James Barnes
13. Birthplace Somerset Co. Md.
MOTHER 14. Maiden name unknown
15. Birthplace unknown
16. Informant Hattie Barnes
Address Mt. Airy Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20 1940 (month) (day) (year)
Cemetery or ~~crematory~~ Asbury Evergreen
Location Eastern av. an North point road Baltimore
18. Funeral director H. M. Snyder
Address Mt. Airy Md.
19. Nov. 18 1940 Chas D Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1940, at 8 H. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1940, to Nov 17 1940 and that I last saw him alive on Nov. 16 1940.

Immediate cause of death Cardio - nephritis
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)
Major findings: —
Of operations
Of autopsy no

DURATION 17 days

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE [signature] Scott Sevin M. D. or other
Address Frederick, Md. Date signed 11-18-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11497

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos., 10 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 4 mos, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9 Prospect Hill
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY MADELINE BATTY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 29, 1923

8. AGE: Years	Months	Days	If less than one day
17	2	15	..... hrs. ..... min.

9. Birthplace: Towson, Maryland (Town, county, and state)
10. Usual occupation: Housework (Domestic)
11. Industry or business: Unknwork
FATHER
12. Name: Alexander Bass
13. Birthplace: Maryland
MOTHER
14. Maiden name: Laura Batty
15. Birthplace: Towson, Maryland
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-16-40 (month) (day) (year)
Cemetery or crematory: Pleasant Rest
Location: Towson, Md. Balto Co.
18. Funeral director: Archibald A. Huddle
Address: 2101 McCulloh St
19. Nov. 13 1940 (Date rec'd by registrar) Albert R. Swankhorn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13th. 1940 at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3rd. 1940 to November 13 1940 and that I last saw her alive on November 13 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1940
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent
Address: Henryton, Maryland
M. D. or other
Date signed: 11/13/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15c

CERTIFICATE OF DEATH

11498

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lucretia V. Berngen

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: George M. Berngen

6(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): October 24, 1857

8. AGE:

Years	Months	Days	If less than one day
83	1	1	hrs. min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Not known
13. Birthplace

MOTHER
14. Maiden name: Not known
15. Birthplace

16. Informant: Ira E. Berngen

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/27/40 (month) (day) (year)

Cemetery or crematory: Stiltz Cemetery

Location: York County, Penna.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 1/26 (Date rec'd by registrar) 19 40 F. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25, 1940, at 9a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from On Nov 23rd 1940, to Nov 25 1940, and that I last saw her alive on Nov 24 1940.

Immediate cause of death: Cardiac Insufficiency

Due to: Acute Colds

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John J. Stewart M. D. or other

Address: Westminster Date signed: Nov 25th 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

11499

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 74 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural near Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas A Blizzard

3. (b) Social Security Number

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, ~~or~~ divorced: widow

6 (b) Name of ~~husband~~ or wife Lollie Taylor

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 74 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Patapsco, Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Peter Blizzard
13. Birthplace Maryland

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant Mrs Calvin Long
Address 512 E. 26th Street, Baltimore, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Nov. 3. 1940
(month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Carrollton, Maryland

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 11/3 1940 L. J. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2nd 1940, at about 5:40 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death Struck by train and body cut to pieces, legs severed, head mangled, etc.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? Cranberry Sta. (City or town) Carroll (County), Md (State)

Injured at home, farm, industry, public place (where?) Railroad Track

Means of injury Struck by train. Injured at work? no

23. SIGNATURE C. L. Billingslea, M. D.
M. D. or other
Actuary, Deputy Medical Examiner

Address Westminster, Md. Date signed 11/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 3 1940
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(46-B) ✓

11500

Reg. Dist. No. 72.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Union Mills (Westminster R.D.)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Mills, Westminster, R.D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Arabella Breighner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Irvin Breighner
6(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb-14-1871

8. AGE: Years	Months	Days	If less than one day
69	9	6	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation House-Work
11. Industry or business Home
FATHER 12. Name Josiah Duttera
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Elmira Shull
15. Birthplace Carroll Co. Md.
16. Informant Irvin Breighner
Address Union Mills, Westminster Md R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 22-1940 (month) (day) (year)
Cemetery or crematory Cemetery
Location Silver Run, Md
18. Funeral director J. M. Little & Son
Address Littlestown, Pa. Pa R.F.D.
19. Nov. 22nd 1940 (Date rec'd by registrar) Calvin T. Bennett, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1940, at 1:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14 1940, to Nov. 20 1940, and that I last saw her alive on Nov. 20 1940.

Immediate cause of death	DURATION
Cancer of the Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Milton A. Katz M.D.
M. D. or other
Address Westminster Date signed Nov. 21, 1940

RECEIVED
DEC 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

11501

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 5 mos., 18 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yrs., 5 mos., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No. 308 North Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eary Burbage

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: ---------
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 28, 1872

8. AGE: Years 68 | Months 3 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Undertaker
11. Industry or business

FATHER
12. Name James Burbage
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Springfield State Hosp. Record
Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 21, 1940 (month) (day) (year)
Cemetery or crematory Berlin
Location Berlin Md.

18. Funeral director J. W. Burbage
Address Berlin Md.

19. Nov. 19 1940 (Date rec'd by registrar) A. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1940, at 1:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7, 1937, to Nov. 18, 1940, and that I last saw him alive on Nov. 18, 1940.

Immediate cause of death	DURATION
Cerebral Arteriosclerosis with Hypertension. prior to	5/31/37
Due to	
Due to	
Other conditions Gangrene of both feet	11/13/40

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D., M. D. or other
Address Sykesville, Md. Date signed 11-19-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11502

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs., 5 mos., 19 days.
Hospital, institution, or street address where death occurred:
Springfield State Hospital.
How long in hospital or institution? 12 yrs., 5 mos., 19 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Howard.
City or town: Lisbon (Rural).
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Orlandy W. Burns.

3. (b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 27, 1904.

8. AGE: Years	Months	Days	If less than one day
36.	4.	14.	..... hrs. ..... min.

9. Birthplace: near Lisbon, Md.
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER
12. Name: Darius Burns.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Campsydell Haines.
15. Birthplace: Unknown.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 13 1940 (month) (day) (year)
Cemetery or crematory: Jennings Chapel
Location: Howard Co. Md.

18. Funeral director: O. A. Beer
Address: Sykesville Md.

19. Nov. 11 1940 (Date rec'd by registrar) O. Harry Beer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1940, at 4. A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1936, to Nov. 10, 1940.
and that I last saw him alive on Nov. 10, 1940.

Immediate cause of death (a)	DURATION
Myocarditis, unspecified.	Unk.
Due to	
Due to	
Other conditions: Mental Deficiency — Congenital.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Request for autopsy refused.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Harry F. Baer, M. D.
M. D. or other
Address: Sykesville, Md. Date signed 11-11-40.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11503

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 16 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution? 8 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 509 Aisquith Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: DOROTHY LORAINE CAMPBELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 3, 1925

8. AGE: Years	Months	Days	If less than one day
15	8	15	hrs. min.

9. Birthplace: Jenkintown, Pennsylvania (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business: Unknown
FATHER 12. Name: James Giles
13. Birthplace: Willow Grove, Pennsylvania
MOTHER 14. Maiden name: Lola Campbell
15. Birthplace: Jenkintown, Pennsylvania
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 21, 1940 (month) (day) (year)
Cemetery or crematory: St. Lukes Cemetery
Location: Sykesville, Md.
18. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. November 18 40 (Date rec'd by registrar) Albert R. Swarbrick Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18, 1940, at 7:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2, 1940, to Nov. 18, 1940 and that I last saw her alive on November 18, 1940
Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1939
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Maryland Superintendent
Date signed: 11/18/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

11504

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD #3
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: John T. Chaney

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margaret Chaney

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): June 9, 1859

8. AGE: Years: 81 Months: 5 Days: 4 If less than one day: hrs. min.

9. Birthplace: Frederick, Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation: Locomotive engineer

11. Industry or business: Railroad

FATHER
12. Name: Unknown
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Maryland

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1940 (month) (day) (year)

Cemetery or crematory: Prospect

Location: near Mt. Airy

18. Funeral director: H. M. Snyder

Address: Mt. Airy

19. Nov. 14 1940 (Date rec'd by registrar) Catherine Stem Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13 1940, at 8.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1940, to Nov. 13 1940 and that I last saw him alive on Nov. 13 1940

Immediate cause of death	DURATION
Chronic myocarditis	Unknown
Due to: Arteriosclerosis	Unknown
Due to:	
Other conditions: Chronic pulmonary emphysema	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lewis Danziger M.D.
M. D. or other

Address: Sykesville, Md. Date signed: 11-13-40

RECEIVED
NOV 30 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11505

Reg. Diat. No. 74

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 29 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 2months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 502 W. Isabelle St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SAMUEL JOSEPH CORNISH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7, 1917

8. AGE: Years	Months	Days	If less than one day
23	4	20	hrs. min.

9. Birthplace: Salisbury, Maryland (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business: Unknown

FATHER
12. Name: Washington W. Cornish
13. Birthplace: Hebron, Maryland

MOTHER
14. Maiden name: Sarah Furr
15. Birthplace: Rockawalker, Maryland

16. Informant: Wm. A. Ventimiglia, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/30/40 (month) (day) (year)
Cemetery or crematory: Rockawalkin
Location: Rockawalkin
18. Funeral director: James R. Stewart
Address: Salisbury Md

19. Nov. 27 19 40 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27th. 19 40 at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29 19 40 to Nov. 27 19 40 and that I last saw her alive on November 27th. 19 40

Immediate cause of death: Pulmonary Tuberculosis. — DURATION: May 1940
Due to: Empyema. — DURATION: 1940
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: O. D. Lee M. D. or other
Address: Henryton, Maryland Date signed: 11/27/40

RECEIVED
DEC 4 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11506

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

(548)

County Carroll — Registration Dist. No. 76

Village or City near Westminster — No. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S. If of foreign birth? — yrs. — mos. — ds.

2. FULL NAME

Nora Pearl Dykman — If U. S. Veteran, specify WAR —

(a) Residence: No. Westminster Md. St., — Ward. —

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Reinhold Dykeman

6. DATE OF BIRTH (month, day, and year): Jan 6, 1887

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	10	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: At Home

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Westminster Md.

FATHER

13. NAME: Geo. T. Schaeffer

14. BIRTHPLACE (city or town) (State or country): Md.

MOTHER

15. MAIDEN NAME: Sarah Hughs

16. BIRTHPLACE (city or town) (State or country): Md

17. INFORMANT (Address): Reinhold Dykman Westminster Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Kriders Cem. Date Nov 16, 1940

19. UNDERTAKER (Address): Albert W. Bereman 440 E. Main St. Westminster

20. FILED 11/16, 1940 — Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: Nov (Month) 12 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1940, to Nov. 12, 1940

I last saw her alive on Nov. 8, 1940; death is said to have occurred on the date stated above, at 11:45 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Malignant Brain tumor	7 months
Metastatic in pelvic bone	

Other Contributory Causes of importance:

Operated on by Dr. W. Dandy at Johns Hopkins Hospital, Baltimore, Md. 9-6-40

Name of operation: Brain tumor (Post) — Date of: June 1940

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury —, 19—

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of Injury —

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify —

(Signed) C. Reese Dunbbens M. D.

(Address) Westminster

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

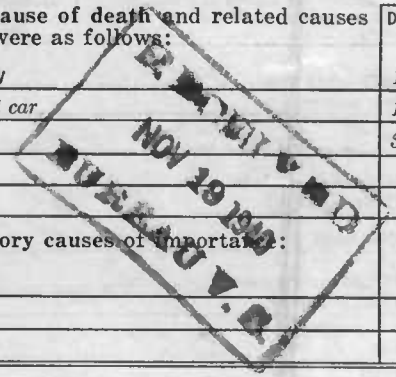
Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*



ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

11507

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Windsor Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maggie Edmondson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Walter Edmondson
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 10, 1890

8. AGE: Years	Months	Days	If less than one day
49	10	21	____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: -----

FATHER
12. Name: William B. Helton
13. Birthplace: Virginia

MOTHER
14. Maiden name: Matilda Lussel
15. Birthplace: Virginia

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 7 1940 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Woodlawn Balto. Co. Md
18. Funeral director: C. M. Walsh
Address: Winfield Md

19. Nov. 5 1940 (Date rec'd by registrar) C. Harry Weaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1940 at 10:40a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1st 1940 to Nov. 4th 1940 and that I last saw her alive on November 4th 1940

Immediate cause of death	DURATION
Coronary thrombosis	few minutes
Due to: Arteriosclerosis	Unknown
Due to:	
Other conditions: Hypertension	Unknown
Diabetes mellitus	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Louis Danziger M.D. M. D. or other
Address: Sykesville, Md. Date signed: 11-4-40

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11508

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. - 15 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs - 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Adele Engel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

7. Birthdate of deceased (mo., day, yr.): August 15, 1900 6.(c) If alive, give age ____ years

8. AGE:

Years	Months	Days	If less than one day
40	3	15	____ hrs. ____ min.

9. Birthplace: Michigan (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: George S. Engel

13. Birthplace: Michigan

MOTHER

14. Maiden name: Adele Young

15. Birthplace:

16. Informant: Records Springfield State Hosp.

Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 4 1940 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville Md.

18. Funeral director: A. N. Steen

Address: Sykesville Md.

19. Dec 5 19 40 A. N. Steen

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 19 40, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 19 40, to November 30, 19 40

and that I last saw h.e alive on November 30 19 40

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1938
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: Alan Jacobs M. D. or other

Address: Springfield St. Hosp. Date signed: 12/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 4 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11599

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 1 month, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 507 Myrtle Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ROSS FAGAN

3.(b) Social Security Number: 209-10-0715

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 7, 1911

8. AGE: Years	Months	Days	If less than one day
29	8	18	hrs. min.

9. Birthplace: Cleveland, Ohio
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown
FATHER 12. Name: William Fagan
13. Birthplace: Ohio
MOTHER 14. Maiden name: Elmira Gaines
15. Birthplace: Ohio
16. Informant: William A. Ventimiglia, M.D.
Address: Henryton, Maryland
17. (Burial, cremation, removal, Which?) Date thereof: 11-30 40 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore Md
18. Funeral director: Adolphus Halstead
Address: 9 & 8 Druid Hill Ave.
19. November 25 40 (Date rec'd by registrar) Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 19 40 at 2:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 27 19 40 to November 24 19 40 and that I last saw h im alive on November 24 19 40

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1940
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

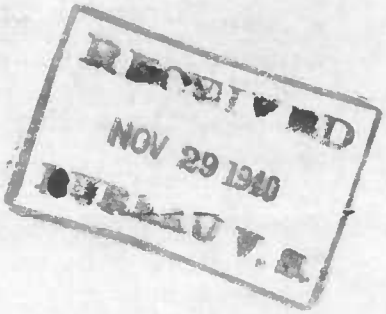
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm A Ventimiglia M.D. M. D. or other
Address: Henryton, Maryland Date signed: 11/25/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
NOV 29 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

11510

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Rural Near Westminster Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Taylorsville

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Rural Near Westminster Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Taylorsville

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Charles Mark Frizzell

3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 28, 1940

8. AGE: Years | Months 4 | Days 1 | If less than one day ___ hrs. ___ min.

9. Birthplace Frederick Md (Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER 12. Name Charles C. Hoofer

13. Birthplace Maryland

MOTHER 14. Maiden name Helen M. Frizzell

15. Birthplace Maryland.

16. Informant Helen M. Frizzell

Address Westminster Md Route 6

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 30, 1940 (month) (day) (year)

Cemetery or crematory Taylorsville

Location Taylorsville, Carroll Co. Md

18. Funeral director C. M. Waltz

Address Winfield Md

19. Dec 5 1940 (Date rec'd by registrar) E. M. Farver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1940, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h— alive on — 19___.

Immediate cause of death Inanition — DURATION 4 mos.

Due to Premature birth

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Marsh, Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 11/29/40

Rec'd from Deputy Reg. Belva A. Pickett. Permit issued Nov. 30, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11511

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: County Carroll. City or town Sykesville, Maryland. (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? 11yrs., 6 mos., 18 days. Hospital, institution, or street address where death occurred: Springfield State Hospital. How long in hospital or institution? 11yrs., 6 mos., 18 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Last residence
State Maryland. County
City or town Baltimore. (If outside city or town limits, write RURAL and give nearest town)
Street No. 3107 Garrison Ave., (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Samuel Gochrach. 3. (b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Married.

6.(b) Name of ~~husband or~~ wife Sarah
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1885 - Exact date unknown.

8. AGE: Years	Months	Days	If less than one day
55.	Unk.	Unk.	..... hrs. ..... min.

9. Birthplace Russia. (Town, county, and state)
10. Usual occupation Cigar Maker.
11. Industry or business
FATHER 12. Name Harry Gochrach.
13. Birthplace Russia.
MOTHER 14. Maiden name Unknown.
15. Birthplace Russia.
16. Informant Springfield State Hosp. Record.
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 30, 1940 (month) (day) (year)
Cemetery or crematory Hebrew Herring Run
Location Balto. Md.
18. Funeral director Jack Lewis Inc
Address 1900 Eutaw Place
19. Nov. 29 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1940 at 8 p. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938 to Nov. 28, 1940, and that I last saw h. alive on Nov. 28, 1940.

	DURATION
Immediate cause of death Cerebral Haemorrhage	36 hrs.
Due to Idiopathic Hypertension	4 mos.(?)
Due to	
Other conditions Dementia Praecox prior to 5-10-'29.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Harry F. Baer, M. D. M. D. or other
Address Sykesville, Md. Date signed 11-28-40.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11512

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 527 N. Fremont Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ESSIE GRAHAM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	COL.	MARRIED

6.(b) Name of husband or wife: Edward Brown
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): September 23, 1897

8. AGE: Years	Months	Days	If less than one day
43	1	19	....hrs. ....min.

9. Birthplace: South Carolina
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown

FATHER
12. Name: Claude Weather
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 14, 1940 (month) (day) (year)
Cemetery or crematory: Mt Zion Cemetery
Location: Baltimore Md.
16. Funeral director: Mrs. Katie R Williams
Address: 322 N. Schroeder St

19. Nov. 11 1940 (Date rec'd by registrar) Albert R. Swankhaven Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11th. 1940 4:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21st. 1940, to November 11 1940
and that I last saw her alive on November 11th. 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent
Address: Henryton, Maryland
M. D. or other
Date signed: 11/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 13 1940
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11513

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 3 mos., 29 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 yr., 3 mos., 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1706 Montray Ave.
(if rural, give LOCATION) Monterey
2.(a) If veteran, name war:

3.(a) FULL NAME: Louise Grayauskas or Gruzausikas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Joseph Grayauskas
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): ~~1877~~ Not known

8. AGE: Years: 58 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Joseph Kleisota
13. Birthplace: Lithuania

MOTHER
14. Maiden name: Mary ?
15. Birthplace: Lithuania

16. Informant: Hospital records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 13 1940 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Road

18. Funeral director: John A. Grebliauckas Jr
Address: 423 S. Caza St

19. Nov. 10 1940 (Date rec'd by registrar) Harry Steen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 10, 1940, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11, 1939 to Nov. 10, 1940 and that I last saw her alive on Nov. 9, 1940

Immediate cause of death	DURATION
Generalized arteriosclerosis	1935
Cerebral thrombosis	1939
Due to: Cerebral thrombosis	Nov. 8, 1940
Hypostatic bronchopneumonia	Nov. 9, 1940
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

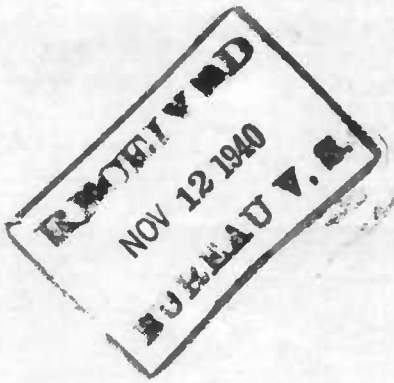
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 11-10-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
NOV 12 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11514

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 11 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Skidmore (nr. Annapolis)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: BESSIE GREEN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: John Green
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): May 6, 1882

8. AGE: Years	Months	Days	If less than one day
58	6	19	...hrs. ...min.

9. Birthplace: Skidmore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Unknown

FATHER
12. Name: Thomas Colbert
13. Birthplace: Skidmore, Maryland

MOTHER
14. Maiden name: Mary Henson
15. Birthplace: Skidmore, Maryland

16. Informant: Wm. A. Ventimiglia, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 28 1940 (month) (day) (year)
Cemetery or crematory: Broadneck
Location: On Rd. to Baltimore 3 mi. from Annapolis
18. Funeral director: Chas. H. Alexander
Address: 43 and 45 Northwest St. Annapolis, Md.

19. Nov. 25 1940 (Date rec'd by registrar) Allen R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 19 40, at 6:07 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14 19 40 to Nov. 25 19 40 and that I last saw her alive on November 25 19 40

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm. A. Ventimiglia M.D. M. D. or other
Address: Henryton, Maryland Date signed 11/25/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1940
BUREAU V. S.

11515

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Taneytown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Anna M. Hafer

3. (b) Social Security Number none

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced married

8 (b) Name of husband or wife Luther B. Hafer

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1, 1874

8. AGE: Years 66 Months 3 Days 27 If less than one day hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Daniel Null
13. Birthplace Md

MOTHER
14. Maiden name Mary A. Ickes
15. Birthplace Md

16. Informant Luther B. Hafer
Address Taneytown Md

17. Burial Date thereof Dec 2 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown. Md

18. Funeral director C O Duss & Son
Address Taneytown, Md.

19. Dec 1 1940 Ethele M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28th 1940, at 2:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939, to Nov. 27th 1940, and that I last saw her alive on Nov. 27th 1940.

Immediate cause of death Carcinoma of upper Sigmoid of Colon — DURATION 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Operation refused

Of autopsy None (done)

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis T. Elliot, M.D.
M. D. or other

Address Taneytown, Md. Date signed Nov. 30 '40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11516

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll County
City or town Sykesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs 7 mo 25 da
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 6 yrs 7 mo 25 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2802 Maryland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Johanna Hollenbaugh

3. (b) Social Security Number

4. Sex F.
5. Color or race W.
6.(a) Single, married, widowed, or divorced widow
6.(b) Name of husband or wife (Unknown) Hollenbaugh
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 19. 1853

8. AGE: Years 87 Months 4 Days 10 If less than one day hrs. min.

9. Birthplace New York City N. Y.
(Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Patrick Luby
13. Birthplace Ireland
MOTHER 14. Maiden name Margaret Donn
15. Birthplace Ireland
16. Informant Hospital Records
Address Sykesville Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 1, 1940 (month) (day) (year)
Cemetery or crematory St Joseph (Dec 1 1940)
Location Taneytown Md
18. Funeral director C O Russ & Son
Address Taneytown Md
19. Nov. 29 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29th 1940, at 10.30 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 5 1934, to Nov. 29 1940
and that I last saw her alive on Nov. 29 1940

	DURATION
Immediate cause of death: Bronchopneumonia	2 days
Due to: Carcinoma of the cecum (Unknown)	
Due to: Arteriosclerosis	6 yrs.
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.
Autopsy results foregoing statement
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D. M. D. or other
Address Sykesville Md Date signed 11-29-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11517

Reg. Dist. No. 81

(M)

1. PLACE OF DEATH:
County: Carroll Co
City or town: Linwood Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Linwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Henry Hollingsworth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Anna Hollingsworth
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 10 - 1855

8. AGE: Years: 85 | Months: 9 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Carroll Co Md
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business:

FATHER
12. Name: Richard Hollingsworth
13. Birthplace: Carroll Co.

MOTHER
14. Maiden name: Serena — Hollingsworth
15. Birthplace:

16. Informant: Elizabeth Hollingsworth
Address: Linwood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-20-40 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Near New Windsor

18. Funeral director: Raymond K. Wright
Address: Union Bridge Md

19. Nov. 19, 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 17, 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to 1940
and that I last saw h[illegible] alive on N.O.U. 1940

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. N Legg, M. D. or other
Address: Union Bridge Date signed 11-18-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 734

CERTIFICATE OF DEATH

11518

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Rural near Westminster, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) about 65 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Cranberry station
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Daniel Joshua Hunter

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Lillie Harris Hunter

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30 1876

8. AGE:

Years	Months	Days	If less than one day
64	11	11	hrs. min.

9. Birthplace Nr. Westminster Carroll Co., Md.
(Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER
12. Name Daniel W. Hunter
13. Birthplace Carroll Co.

MOTHER
14. Maiden name Mary A. Lockard
15. Birthplace Carroll Co.

16. Informant Mrs. Joshua Hunter
Address West Minster, Md.

17. Burial Date thereof 11 13 40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lesters Cemetery

Location Nr. Westminster, Md.

18. Funeral director J. E. Myers, Jr.

Address Westminster, Md.

19. 11/17 19 40 L. L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/1940, at 5:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/2/1940, to 11/10/1940, and that I last saw h[e] alive on 11/9/1940.

Immediate cause of death	DURATION
Cerebral embolism	8 days
Due to myocarditis	
Due to Arteriosclerosis	
Other conditions Hypotension	

(Include pregnancy within 3 months of death)

Major findings:

Ot operations

Ot autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE James E. Schell M. D. or other

Address Reisterstown Md. Date signed 11/10/40

RECEIVED
DEC 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11519

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 20 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 4 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Talbot St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SARAH MURRIN JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Nathan Johnson

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): October 2, 1894

8. AGE: Years	Months	Days	If less than one day
46	1	13	....hrs. ....min.

9. Birthplace: West Central Africa (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Unknown

FATHER — 12. Name: George Richard Murrin

FATHER — 13. Birthplace: South America

MOTHER — 14. Maiden name: Elizabeth Burnett

MOTHER — 15. Birthplace: South America

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18 1940 (month) (day) (year)

Cemetery or crematory:

Location: Easton, Md.

18. Funeral director: James A. Spence

Address: Easton, Md.

19. Nov. 15 1940 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15 19 40 at 3:35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 19 40 to Nov. 15 19 40 and that I last saw her alive on November 15 19 40

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1940

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.

Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 11/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11520

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Union Mills
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 23 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Mills Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas William Kemp

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Annie Shriner
6(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Aug. 23 1874

8. AGE: Years	Months	Days	If less than one day
66	2	20	hrs. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual occupation Journalist
11. Industry or business
FATHER 12. Name Charles L. Kemp
13. Birthplace Maryland
MOTHER 14. Maiden name Elizabeth C. Bungle
15. Birthplace Maryland
16. Informant Mrs Annie Kemp
Address Union Mills Carroll Co. Md.
17. Burrial (Burial, cremation, or removal. Which?) Date thereof Nov. 16 1940 (month) (day) (year)
Cemetery or crematory Silversum Cemetery
Location Silversum Carroll Co. Md.
18. Funeral director H Bankard & Son
Address Westminster, Md.
19. Nov. 14 1940. (Date rec'd by registrar) Calvin Bankard, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1940, at 3:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 26 1940, to Nov. 13 1940, and that I last saw him alive on Nov. 13 1940.

	DURATION
Immediate cause of death Metastatic carcinoma to stomach and glands	
Due to primary carcinoma of prostate gland	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Milton A Katz M.D.
M. D. or other
Address Westminster, Md Date signed Nov. 14

RECEIVED
DEC 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

11521

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural Near

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 66

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Rural No. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles W. King

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of ~~husband~~ or wife Clara Phillips King

6(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov. 13 - 1873

8. AGE: Years	Months	Days	If less than one day
66	11	23	hrs. min.

9. Birthplace Sandymount Carroll Co. Md.

(Town, county, and state)

10. Usual occupation Farmer + Dairyman

11. Industry or business

FATHER 12. Name Julius King

13. Birthplace Germany

MOTHER 14. Maiden name Amalia Dryer

15. Birthplace Germany

16. Informant Edwin S. Gehr

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8-1940 (month) (day) (year)

Cemetery or crematory Kriedler Cemetery

Location Near Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster, Md.

19. 11 6 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6th 1940, at 1 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6th 1940, to 19, and that I last saw him alive on Nov 6th 1940.

	DURATION
Immediate cause of death Organic Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Edmund Stewart M. D. or other

Address Westminster Md. Date signed Nov 6th 1940

RECEIVED
DEC 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11522

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 8 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 3 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City, Route #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: OPHELIA DEVADA KING

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 27, 1921

8. AGE: Years	Months	Days	If less than one day
19	1	25	hrs. min.

9. Birthplace: Beaver Dam, Maryland (Town, county, and state)
10. Usual occupation: Dish Washer
11. Industry or business: Unknown

FATHER
12. Name: Fred King
13. Birthplace: Unknown

MOTHER
14. Maiden name: Vesta Selby
15. Birthplace: Virginia

16. Informant: Wm. A. Ventimiglia, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 24 1940 (month) (day) (year)
Cemetery or crematory: St. James Cemetery
Location: Pocomoke City, Md.

18. Funeral director: John A. Bradshaw
Address: Pocomoke City, Md.

19. NOV. 20 1940 (Date rec'd by registrar) Ethel R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1940, at 5:05P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1940, to November 20 1940 and that I last saw h...er alive on November 20 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: July 1940
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Ventimiglia, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 11/20/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 4 1940
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

11523

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 19 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 4 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1943 Booth St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: AMANDA STOVALL LIGINS (Leggs)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married (separated)

6.(b) Name of husband or wife: Major Stovall
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 16, 1918

8. AGE:

Years	Months	Days	If less than one day
22	6	11	..... hrs. ..... min.

9. Birthplace: Spartansburg, S. Carolina
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown
FATHER
12. Name: Isaac Ligins
13. Birthplace: South Carolina
MOTHER
14. Maiden name: Annie Robinson
15. Birthplace: Spartansburg, S. Carolina
16. Informant: Wm. A. Ventimiglia, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/30/40 (month) (day) (year)
Cemetery or crematory: Ant Auburn Cem
Location: West Port
18. Funeral director: Mrs Katie R Willicas
Address: 322 N Schroeder St
19. Nov. 25 1940 (Date rec'd by registrar) A R Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 1940, at 9:45A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1940, to Nov. 27 1940 and that I last saw her alive on November 27, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: ..... Date of op.
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Wm. A. Ventimiglia, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 11/27/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134)

CERTIFICATE OF DEATH

11524

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution? 1 month, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LAURA VIRGINIA MASON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 25, 1923

8. AGE: Years	Months	Days	If less than one day
16	11	19	..... hrs. ..... min.

9. Birthplace: Snow Hill, Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown
FATHER 12. Name: Wilmore Mason
13. Birthplace: Ikenback County, Virginia
MOTHER 14. Maiden name: Dorothy Bishop
15. Birthplace: Snow Hill, Maryland
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal (Which?)) Date thereof: Nov. 16, 1940 (month) (day) (year)
Cemetery or crematory: Snow Hill
Location: Snow Hill, Md.
18. Funeral director: Clay E. Dennis
Address: Snow Hill, Md.
19. Nov. 13, 1940 (Date rec'd by registrar) Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13th, 1940 at 3:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30, 1940 to Nov. 13, 1940 and that I last saw h... or alive on November 30, 13, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed: 11/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11525

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 17 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
MARY HELEN MASON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 22, 1920

8. AGE: Years	Months	Days	If less than one day
20	8	21	hrs. min.

9. Birthplace: Leonardtown, Maryland (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: Unknown

FATHER
12. Name: Phil Mason
13. Birthplace: California, Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: California, Maryland

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Nov 13 1940 (month) (day) (year)
Cemetery or crematory: City Morgue
Location: Balto. Md.
18. Funeral director: Mrs Frances Hynsley
Address: 578 W. Biddle St.

19. Nov. 12 1940 (Date rec'd by registrar) Albert R. Swadburn Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12th. 1940 at 4:25A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 26th 1940 to November 12th 1940
and that I last saw her alive on November 12th. 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	August 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Superintendent
Address: Henryton, Maryland Date signed 11/12/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

11526

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 22 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch

How long in hospital or institution? 10 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 659 Haw Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
Carrie Lene Maybanks

3.(b) Social Security Number
216-01-2311

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	Married

6.(b) Name of husband or wife: Willie Maybank

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): December 30, 1913

8. AGE: Years	Months	Days	If less than one day
27	10	25	....hrs. ....min.

9. Birthplace: Staunton, Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER
12. Name: Henry Jones
13. Birthplace: Staunton, Virginia

MOTHER
14. Maiden name: Alice Pryor
15. Birthplace: Staunton, Virginia

16. Informant: William Ventimiglia, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 28, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore, Maryland

18. Funeral director: Joseph A. Lively
Address: 409 N Mount St Baltimore Md

19. Nov. 24 1940 (Date rec'd by registrar) Albert R. Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 1940, at 12:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 1940, to Nov. 24 1940 and that I last saw her alive on November 24 1940

Immediate cause of death: Pulmonar y Tuberculosis — DURATION: April 1939

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Ventimiglia M.D. M. D. or other

Address: Henryton, Maryland Date signed: 11/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 29 1940
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

11527

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 8 mos., 23 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 yrs., 8 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2763 Baker St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Lena Nash

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 2, 1872

8. AGE: Years	Months	Days	If less than one day
68	1	21	hrs. min.

9. Birthplace: Savannah, Ga.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Ward
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26, 1940 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto., Md.
18. Funeral director: Wm Cook
Address: 1217 N. Paul St.
19. Nov. 24, 1940 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23, 1940 at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 1938, to Nov. 23, 1940
and that I last saw h.e.r. alive on Nov. 23, 1940

Immediate cause of death	DURATION
Generalized arteriosclerosis	6 yrs.
Cerebral thrombosis	10 days
Due to: Hypostatic bronchopneumonia	6 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 11-24-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

11528

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Marlyn and Eastern Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John F. Neimeyer

3.(b) Social Security Number: 214-03-4058

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lena Agnes Roth
6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): August 15, 1902.

8. AGE: Years	Months	Days	If less than one day
38	2	24	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Lithographer
11. Industry or business: ----

FATHER
12. Name: Charles Neimeyer
13. Birthplace: Sweden

MOTHER
14. Maiden name: Mary Traufelter
15. Birthplace: Baltimore, Maryland

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 14th 1940 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Baltimore Md
18. Funeral director: John L. Connelly
Address: Essex, Md.
19. 11-12-1940 (Date rec'd by registrar) C. Barry Ebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 19 40 at 5:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9, 19 40, to November 12 19 40
and that I last saw him alive on ....19....

Immediate cause of death	DURATION
Delirium tremens	2 weeks
Due to: ~~Bronchial~~ Avitaminosis B	Unknown
Due to: Chronic alcoholism	20 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results: Refused autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

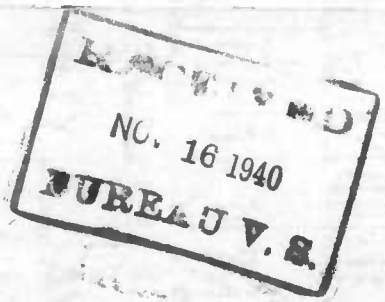
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lewis Dangerfield, M. D. M. D. or other
Address: Sykesville, Md. Date signed 11-12-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


NOV 16 1940
BUREAU U.S.

11529

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 21 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.: ----- (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Bowie Owens

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: ~~Married~~ Divorced

6.(b) Name of husband or wife: Maud Holt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 29, 1870

8. AGE: Years 70 Months 0 Days 2 If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business:

FATHER
12. Name: James Owens
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maria Louise Bowie
15. Birthplace: Maryland

16. Informant: Records of Springfield State Hospital, Sykesville, Md.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 4, 1940 (month) (day) (year)

Cemetery or crematory: Owensville

Location: Owensville, Md.

18. Funeral director: O. H. Weer

Address: Sykesville, Md.

19. Nov. 2 1940 (Date rec'd by registrar) O. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1st 1940, at 7:35 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10 1940, to Nov. 1 1940 and that I last saw him alive on November 1 1940

Immediate cause of death	DURATION
Pulmonary tuberculosis	Over 3 months
Due to	
Due to	
Other conditions: arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lewis Danziger, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 11-2-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11530

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. 7701 Old Georgetown Rd. (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Hezekiah Eugene Perrell

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Mae Perrell

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 21, 1867

8. AGE: Years	Months	Days	If less than one day
73	8	8	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Assistant Engineer

11. Industry or business: American Ice Co., Wash. D.C.

FATHER — 12. Name: John Perrell

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: .....

MOTHER — 15. Birthplace: Maryland

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov 29, 1940 (month) (day) (year)

Cemetery or crematory: Bethesda Md.

Location: Bethesda Md.

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Md.

19. Nov 29 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1940, at 11:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 23 1940, to November 29 1940 and that I last saw him alive on November 29 1940

Immediate cause of death	DURATION
Chronic myocarditis	Unknown
Due to: arteriosclerosis	Unknown
Due to:	.....
Due to:	.....
Other conditions: Senile psychosis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lewis Dunajr. M. D. (M. D. or other)

Address: Sykesville, Md. Date signed: 11-29-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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11531

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mo. 21 da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 7 mo. 21 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Washington D.C. (If outside city or town limits, write RURAL and give nearest town)

Street No. 1627 Myrtle St. N.W. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Julia Pharr

3. (b) Social Security Number

4. Sex F.

5. Color or race W.

6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife John T. Pharr

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 5, 1867

8. AGE: Years 73 Months 6 Days 0 If less than one day ..... hrs. ..... min.

9. Birthplace Pr. Geo. Co. Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Thomas Woods

13. Birthplace Georgia

MOTHER 14. Maiden name Mary (unknown)

15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8, 1940 (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Md.

18. Funeral director Clarnowitha & Son

Address 3615 Chestnut Ave.

19. Nov. 5 1940 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5th 1940, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1940, to Nov. 5 1940 and that I last saw her alive on Nov. 5, 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 da.
Due to Arteriosclerosis	3 yr.
Due to Lobar Pneumonia	1 da.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Maud M. Rees M.D. M. D. or other

Address Sykesville, Md. Date signed 11-5-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11532

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 309 E. Main St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 32 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 309 E. Main St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: John Poisel

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Josephine A. Winkler

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 4, 1857

8. AGE: Years	Months	Days	If less than one day
83	1	16	hrs. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual occupation: Harness Maker

11. Industry or business:

FATHER — 12. Name: Not known

13. Birthplace:

MOTHER — 14. Maiden name: Not known

15. Birthplace:

16. Informant: Miss Elizabeth Poisel

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/23/40 (month) (day) (year)

Cemetery or crematory: St. John's Catholic

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 11/21/40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20, 1940, at 9p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1940, to Nov 20 1940, and that I last saw him alive on Nov 20 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days.
Due to Arterio Sclerosis & senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other

Address: Westminster Md. Date signed: Nov 21/40

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11533

74

Reg. Diat. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Fairlee, Chestertown P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route # 2, Box 86
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: DELLA BROWN POLLIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widow

6.(b) Name of husband or wife: James Pollis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 28, 1889

8. AGE: Years	Months	Days	If less than one day
50	10	19	hrs. min.

9. Birthplace: Kent County, Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Unknown

FATHER
12. Name: William Brown
13. Birthplace: Georgetown, Maryland

MOTHER
14. Maiden name: Annie Johnson
15. Birthplace: Georgetown, Maryland

16. Informant: Wm. A. Ventimiglia, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 20, 1940 (month) (day) (year)
Cemetery or crematory: Georgetown Cemetary
Location: Fairfax - Maryland
18. Funeral director: Asbury Henry
Address: Chestertown R.D. #2, Md.

19. Nov. 16 1940 (Date rec'd by registrar) Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16 1940 at 1:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23 1940 to Nov. 16 1940 and that I last saw h... er alive on November 16 1940

Immediate cause of death	DURATION
Pulmonary hemorrhage	May 1940
Due to: Pulmonary Tuberculosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Ventimiglia M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 11/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

11534

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (92a)

County Carroll Registration Dist. No. 74

Village or City Marriottsville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Eugene Garrison Sellman If U. S. Veteran, specify WAR

(a) Residence: No. Marriottsville St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) March 31, 1872

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Watchman

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Soap stone quarry

10. Date deceased last worked at this occupation (month and year) Oct 1939

11. Total time (years) spent in this occupation 2

12. BIRTHPLACE (city or town) Carroll Co. Gaithers (State or country) Md

FATHER

13. NAME Charles William Sellman

14. BIRTHPLACE (city or town) ? (State or country)

MOTHER

15. MAIDEN NAME Elenara Day

16. BIRTHPLACE (city or town) ? (State or country)

17. INFORMANT Susie Sellman (Address) Marriottsville, Md.

18. BURIAL, CREMATION, OR REMOVAL Place Mt View Cem. Date Nov 5, 1940

19. UNDERTAKER C. N. Steen (Address) Sykesville Md.

20. FILED Nov. 2, 1940 C. Harry Steen Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November (Month) 2 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct 27, 1940, to , 19

I last saw him alive on Oct 27, 1940; death is said to have occurred on the date stated above, at 9:30 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Coronary Heart Disease	1940
Other Contributory Causes of Importance: Valvular Heart Disease	
Aortic Stenosis	1936 ?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Jacob T. Jensen M. D.

(Address) Sykesville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11535

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25yrs 4mos 16 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 25yrs 4mos 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1912 Meadow St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME
Allen Essex Shipley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): about 1869

8. AGE: Years	Months	Days	If less than one day
71			hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ?
FATHER 12. Name: John T. Shipley
13. Birthplace: Maryland
MOTHER 14. Maiden name: Jennie Walters
15. Birthplace: Maryland
16. Informant: Hospital Record
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 11-40 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore
18. Funeral director: Wm Cook
Address: 1217 St Paul St
19. Nov. 8 1940 (Date rec'd by registrar) C. Harry Meier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8, 1940 at 6:15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1, 1938, to Nov 8 1940
and that I last saw him alive on Nov. 8 1940

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 hour
Due to: Arteriosclerosis	?
Due to:	
Other conditions: Mental Deficiency, Schizophrenia	Life Since 25 yrs. of age

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Samuel Barkoff M.D.
M. D. or other
Address: Sykesville, Md. Date signed: 11/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

NOV 14 1940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11537

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 923 N. Calhoun St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY ELIZABETH SMITH

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 1, 1918

8. AGE: Years	Months	Days	If less than one day
22	7	5	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Beauty Operator
11. Industry or business: Unknown
FATHER 12. Name: Thomas Ball
13. Birthplace: Unknown
MOTHER 14. Maiden name: Helen Smith
15. Birthplace: Unknown
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. (Burial, cremation, or removal. Which?) Date thereof 11-8-40 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore
18. Funeral director: Adolphus Hobbs
Address: 918 Druid Hill Ave.
19. November 6, 19 40 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6, 1940, at 7:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15, 1940, to November 6, 1940 and that I last saw her alive on November 6, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1940
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
Address: Superintendent Henryton, Maryland M. D. or other
Date signed: 11/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11536

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr - 11 months

Hospital, Institution, or street address where death occurred: Springfield State Hosp.

How long in hospital or institution? 1 yr - 11 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto. City

City or town: Balto.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1501 N. Bond St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

E. Burke Stirling (Stirling)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 7, 1901

8. AGE: Years: 39 | Months: 8 | Days: 16 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Hercules Nut Co.

FATHER

12. Name: W. Maitland Stirling

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Eleanor Burke

15. Birthplace: Maryland

16. Informant: Records Springfield State

Address: Sykesville, Md. Hosp.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 26, (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Edmondson Ave.

18. Funeral director: Geo. E. Pulk Inc.

Address: 1735 Hanford Ave

19. Nov 23 1940 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 1940, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20 1940, to November 23 1940

and that I last saw him alive on November 22 1940

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 2 yrs.

Due to: ____

Due to: ____

Other conditions: ____

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Alan Jacobsen, M. D. or other

Address: Springfield St. Hosp. Date signed: 11-23-40

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11538

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs., 2 mos., 2 days

Hospital, institution, or street address where death occurred: Springfield State Hosp. ~~26 yrs., 2 mos., 2 days~~

How long in hospital or institution? 26 yrs., 2 mos., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 816 William St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Howard C. Tall

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1895

8. AGE: Years: 45 Months: 7 Days: 18 If less than one day: hrs. min.

9. Birthplace: Baltimore City, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER

12. Name: H. P. Tall

13. Birthplace: Dorchester Co.

MOTHER

14. Maiden name: Millison N. Davis

15. Birthplace: Baltimore, Md

16. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 8, 1940 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville, Md

18. Funeral director: G. Howard Strong

Address: 715 Light St.

19. Nov. 6 1940 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 6, 1940 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sep. 4, 1914, to Nov. 6, 1940 and that I last saw him alive on Nov. 6, 1940

Immediate cause of death	DURATION
Hypertensive cardiovascular disease	6 yrs.
Myocardial degeneration	5 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: 11-7-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 11 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 7 11539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (Rural near)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Home

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Life 6-7yrs. 17da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville (Rural near) Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Oakland Mills
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Susie Melvina Tillman (nee Schafer)

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Lawrence Tillman

6(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): October 27, 1883

8. AGE:

Years	Months	Days	If less than one day
57	—	17	hrs. min.

9. Birthplace: Guynnbrook Station
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Charles W. Schafer
13. Birthplace: Baltimore County

MOTHER
14. Maiden name: Susie Engle
15. Birthplace: Baltimore County

16. Informant: Mary B. Tillman
Address: Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Nov. 17, 1940
(month) (day) (year)

Cemetery or crematory: Old Oakland Cemetery

Location: Sykesville, Md.

18. Funeral director: Wm. Berryman & Sons

Address: Reisterstown, Md.

19. Nov 17 1940 Harry Haas
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/14/1940, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/1/1940, to 11/14/1940 and that I last saw h[illegible] alive on 11/14/1940

Immediate cause of death	DURATION
Pneumonia Hypostatic	
Due to arteriosclerosis	
Due to —	
Other conditions Nephritis chronic	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James L. Sadtler, M. D. or other

Address: Reisterstown, Md. Date signed: 11/14/40

RECEIVED
DEC 4 1920
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

11540

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Delbert Unger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Annie Unger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60			..... hrs. ..... min.

9. Birthplace: Morgan Co W. Va
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Wm U Unger
13. Birthplace: Morgan Co W. Va

MOTHER
14. Maiden name: Fannie Morristow
15. Birthplace: Morgan Co W. Va

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4 1940 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Near Hancock, Md.

18. Funeral director: Snyder-Rowland

Address: Hancock Md

19. Nov 4 1940 (Date rec'd by registrar) C. Harry Rice Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1940 at 2:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15 1940 to Nov. 4 1940 and that I last saw him alive on November 4 1940

Immediate cause of death: Cerebral hemorrhage — DURATION: 72 hrs

Due to: Arteriosclerosis

Due to:

Other conditions: Generalized Arteriosclerosis — Prior Admissio

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Alan Jacobson M. D. or other

Address: Springfield State Hosp. Date signed: 11/4/40

RECEIVED
DEC 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

11541

Reg. Dist. No. 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural nr. Bird Hill
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.D. #6 Westminster, Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Agnes Alvata Welch

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

B (b) Name of husband ~~or wife~~: Geo. H. Welch

6(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): July 12, 1858

8. AGE:

Years	Months	Days	If less than one day
82	3	26	____ hrs. ____ min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: William Williams
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Nailer
15. Birthplace: Maryland.

16. Informant: Mr. Frank Welch
Address: R.D. Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 12, 1940 (month) (day) (year)

Cemetery or crematory: Deer Park.

Location: Smallwood, Md.

18. Funeral director: C. M. Watts

Address: Winfield, Md.

19. 11/14/40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8, 1940 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ 19__ to Nov. 8th 1940, and that I last saw h__ alive on Nov. 6th 1940.

	DURATION
Immediate cause of death: Chronic Myocarditis	10 yrs.
Due to: Senility	10 yrs
Due to:	
Other conditions: Herpes Zoster	2 weeks

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. F. Billingslea, M.D.
M. D. or other

Address: Westminster, Md. Date signed 11/11/40.

RECEIVED
DEC 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11542

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years - 8 mo. 16 days -

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 11 years 8 mo. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2736 N. Calvert Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Helen Stuart White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) December 20 - 1886

8. AGE: Years	Months	Days	If less than one day
53	9	21	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Isaac Stull White
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden name: Alice O. Sedley
15. Birthplace: St. Marys County

16. Informant: Alice O. White
Address: 2736 N. Calvert St. Balt. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12 1940 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md.

18. Funeral director: A. N. Heer

Address: Sykesville Md.

19. Nov. 12 1940 A. Nancy Heer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 1940 at 9:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 16 1940, to November 10 1940

and that I last saw h.er alive on November 8 1940

Immediate cause of death	DURATION
Carcinoma of Digestive Tract and Peritoneum	Known Sept 19th
Due to:	1940
Due to:	
Other conditions: Carcinoma of Breast	1935

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of Digestive Tract and Peritoneum Date of op. Sept 19-1940

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Beeler M.D. (M. D. or other)

Address: Sykesville, Md. Date signed: Nov. 10-1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 16 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11543

74

Reg. Dist. No.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 2 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch

How long in hospital or institution? 10 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1526 E. Monument St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DOROTHY ETHEL WINDER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 2, 1925

8. AGE: Years	Months	Days	If less than one day
15	10	19	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: Unknown

FATHER

12. Name: Alexander Winder

13. Birthplace: Whitestone, Virginia

MOTHER

14. Maiden name: Agnes Keene

15. Birthplace: Cambridge, Maryland

16. Informant: Wm. A. Ventimiglia, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/25/40 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Balto., Md.

18. Funeral director: Peter F. Young

Address: 804 N. Caroline St.

19. Nov. 21 1940 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21 1940 at 8:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 1940 to Nov. 21 1940 and that I last saw her alive on November 21 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1939
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Ventimiglia M.D. M. D. or other

Address: Henryton, Maryland Date signed: 11/21/40

RECEIVED
DEC 4 1940
BUREAU V. S.